Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)
16 **DE Admin. Code** 13000, 15000, 18000

PROPOSED

PUBLIC NOTICE

Postpartum Continuous Eligibility

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of 31 **Del. C.** §512, Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DHSS/DMMA) is proposing to amend the Division of Social Services Manual (DSSM), Title XIX Medicaid State Plan, and Title XXI Delaware Health Children's Program State Plan regarding Postpartum Continuous Eligibility and make a technical correction in the DE state plan to the medical assistance program Single State Agency name.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to, Planning and Policy Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906, by email to Nicole.M.Cunningham@delaware.gov, or by fax to 302-255-4413 by 4:30 p.m. on August 31, 2022. Please identify in the subject line: Postpartum Continuous Eligibility.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Division of Social Services Manual (DSSM), Title XIX Medicaid State Plan, and Title XXI Delaware Health Children's Program State Plan regarding Postpartum Continuous Eligibility and make a technical correction in the DE state plan to the medical assistance program Single State Agency name.

Statutory Authority
42 C.F.R. § 435.116
(2105(a)(4)(A) of the SSA
42 CFR 457.342
435.926; 2107(e)(1)(J)
1902(e)(16) of the SOA

Background
Sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) give states a new option to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP beginning April 1, 2022. The newly extended postpartum coverage option offers states an opportunity to provide care that can reduce pregnancy-related deaths and severe maternal morbidity, and improve continuity of care for chronic conditions such as diabetes, hypertension, cardiac conditions, substance use disorder, and depression. More than half of pregnancy-related deaths occur in the 12-month postpartum period, and 12 percent occur after six weeks postpartum.

DMMA has elected to implement options which will allow extend postpartum coverage from 60 days to 12 months for Medicaid and DHCP recipients. The 12-month postpartum period will begin on the last day of a beneficiary's pregnancy and extend through the end of the month in which the 12-month period ends. Individuals will be entitled to the extended postpartum coverage regardless of the reason the pregnancy ends. Extending this benefit will provide needed medical services to Medicaid and DHCP recipients.

Summary of Proposal
Purpose
The purpose of this proposed regulation is to implement postpartum continuous eligibility and make a technical correction in the DE state plan to the medical assistance program Single State Agency name.

Summary of Proposed Changes
Effective for services provided on and after July 1, 2022 DHSS/DMMA proposes to amend the Division of Social Services Manual (DSSM), Title XIX Medicaid State Plan, and Title XXI Delaware Health Children's Program State Plan regarding Postpartum Continuous Eligibility and make a technical correction in the DE state plan to the medical assistance program Single State Agency name.

Public Notice
In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 440.386 and the *state* public notice requirements of Title 29, Chapter 101 of the **Delaware Code**, DHSS/DMMA gives public notice and provides an open comment period for 30 days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments must be received by 4:30 p.m. on August 31, 2022.

Centers for Medicare and Medicaid Services Review and Approval
The provisions of this state plan amendment (SPA) are subject to approval by the Centers for Medicare and Medicaid Services (CMS). The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon public comment and/or CMS feedback. The final version may be subject to significant change.

Provider Manuals and Communications Update
Also, there may be additional provider manuals that may require updates as a result of these changes. The applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals and/or Delaware Medical Assistance Portal will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding DMAP updates. DMAP updates are available on the Delaware Medical Assistance Portal website: https://medicaid.dhss.delaware.gov/provider

Fiscal Impact

	Medicaid Federal Fiscal Year 2023	**Medicaid** Federal Fiscal Year 2024
Federal funds	$ 2,898,000	$ 3,042,900
General (State) funds	$ 1,932,000	$ 2,028,600

	SCHIP Federal Fiscal Year 2023	**SCHIP** Federal Fiscal Year 2024
Federal funds	$ 5,533	$ 11,620
General (State) funds	$ 2,667	$ 4,760

Revision: HCFA-PM 91-4 (BPD) OMB No. 0938
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT STATE: DELAWARE

Citation

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

42 CFR 430.10

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

(Single State Agency)

Submits the following State plan for the medical assistance program, and hereby agrees the administer the program in accordance with the provisions of this State plan, the requirements of title XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

TN No. SPA	Approval Date
Supersedes	
TN No. SPA #300	Effective Date July 1, 2022

~~STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT~~
~~STATE/TERRITORY:~~ ~~**DELAWARE**~~

~~Agency~~	~~Citation(s)~~	~~Condition or Requirement~~
		~~A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)~~
	~~1902(a)(10) (A)(i)(V) and 1905(m) of the Act~~	~~10. Individuals other than qualified pregnant women andchildren under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.~~
	~~1902(e)(5) of the Act~~	~~11. a. A woman who, while pregnant, was eligible for applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.~~
	~~1902(e)(6) of the Act~~	~~b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.~~

13000 Medical Assistance Program Overview

13405 Pregnant Women And Infants

Statutory Authority
42 CFR 435.116
42 CFR 435.170

A pregnant woman who would is found to be eligible for Medicaid if her infant were born may and receives services during her pregnancy will continue to be eligible for Medicaid from verification of her pregnancy until at least 60 days post-partum. 12 months after the pregnancy ends. Eligibility will be a continuous 12 month period after the pregnancy ends unless one the of the following applies:

- The woman requests Medicaid termination
- The woman moves out of state
- It is found that eligibility was determined incorrectly because of error or fraud, abuse, or perjury attributed to the woman
- Death

Infants born to Medicaid eligible mothers are deemed eligible for Medicaid for one year as long as the mother remains eligible and the child remains in the house with the mother.

See 15200.6 Postpartum Period

15000 Family and Community Medicaid Eligibility Groups

15200.1 Definitions

Statutory Authority
42 CFR 435.116
42 CFR 435.170

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise:

"**Pregnant Woman**" means a woman during pregnancy and the post partum period, which begins on the date the pregnancy ends, extends 60 days 12 months, and then ends on the last day of the month in which the 60 day 12 month period ends.

See 15200.1 Definitions - History

15200.6 Postpartum Period

Statutory Authority
42 CFR 435.116
42 CFR 435.170

The 60 day 12 month postpartum period is a mandatory extension of coverage for women who were determined eligible in the month of birth or the pregnancy ends, in a month prior to the month of birth the pregnancy ends (while still

pregnant), or who received services while pregnant during a period of retroactive eligibility. A woman cannot apply and be found eligible for the postpartum period alone. Coverage begins on the day the pregnancy ends and continues through the last day of the month in which the ~~60 days end~~ 12 months ends.

Undocumented aliens are not eligible for the postpartum period.

18000 Delaware Healthy Children Program

18700 Premium Requirements

Statutory Authority
42 C.F.R. 435.926

Families with eligible children are required to pay a premium in order to receive coverage. The premium is per family per month regardless of the number of eligible children in the family. The monthly premium will vary according to age, household size and family income as follows:

Age	Percent Federal Poverty Level based on Household size	Monthly Premium
1 through 5	143% through 159% FPL	$10.00
6 through 18	134% through 159% FPL	$10.00
1 through 18	160% through 176% FPL	$15.00
1 through 18	177% through 212% FPL	$25.00

Payments that are less than one (1) month's premium will not be accepted.

Coverage begins the first of the month following payment of the initial premium. Payments for the initial premium will be accepted through a monthly cut-off date known as the authorization date. The authorization date is set by the automated eligibility system. If payment of the initial premium is received by the authorization date, coverage under DHCP will be effective the following month. Premium payments for ongoing coverage will be accepted through the last day of the month.

Families will be able to pay in advance and purchase up to one year's coverage. The following incentive is offered for advance payments:

Pay three (3) months – get one (1) premium free month

Pay six (6) months – get two (2) premium free months

Pay nine (9) months – get three (3) premium free months.

The advance premium payments for coverage may extend beyond the scheduled eligibility renewal. If the child is determined to be ineligible, the advance premium payments will be refunded to the family.

Coverage will be cancelled when the family is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. If one premium payment is received by the last day of the cancellation month, coverage will be reinstated.

Families who lose coverage for nonpayment of premiums will have received two unpaid months of coverage. Families who are cancelled for nonpayment of premiums may reenroll at any time without penalty. Reenrollment will begin with the first month for which the premium paid.

Good cause for nonpayment of premiums will be determined on a case-by-case basis.

Postpartum 12 Month Continuous Eligibility Exception
Coverage for any child that is pregnant, or within the 12-month postpartum period, may not be terminated for nonpayment.

18 DE Reg. 375 (11/01/14)
20 DE Reg. 639 (02/01/17)
22 DE Reg. 299 (10/01/18)

18800 Continuous Eligibility

Statutory Authority
42 CFR. 435.926
42 CFR. 435.118

18800.1 Continuous Eligibility for Target Low-Income Children

Continuous eligibility means continued eligibility under DHCP during the 12-month period of time between the first month of eligibility and the next scheduled renewal.

The initial month of the continuous period of eligibility is the first month of eligibility. A new period of continuous eligibility will be established beginning with the month following the last month of the previous period of continuous eligibility, when a scheduled renewal is completed and the child is determined to be eligible. A new 12-month period of continuous eligibility will also begin after any break in DHCP eligibility.

There is no interruption of the continuous eligibility period because of an increase in household income. This includes an increase in income because of a change in family size. If there is a decrease in household income or an increase in family size, eligibility will be redetermined. A decrease in income could result in the family becoming eligible for Medicaid or the child remaining eligible for DHCP with a lower premium. If the decrease in income results in a lower premium for the family, the child will receive a new 12-month period of continuous eligibility.

A child who is determined eligible for DHCP remains eligible for a 12-month period of continuous ~~eligibility unless the child:~~ eligibility. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

- ~~turns age 19;~~
- ~~dies;~~
- ~~acquires comprehensive health insurance;~~
- ~~is eligible for the State health benefits plan;~~
- ~~is eligible for Medicaid;~~
- ~~is an inmate of a public institution;~~
- ~~is a patient in an institution for mental disease;~~
- ~~no longer meets the general eligibility requirements.~~

- The child turns 19 years old;
- The child or child's representative requests a voluntary termination of eligibility;
- The child ceases to be a resident of the State;
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative;
- The child dies;
- The child becomes eligible for Medicaid; or
- There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the DHCP State Plan.

18800.2 12-month Postpartum Continuous Eligibility

Continuous eligibility is provided to targeted low-income children who, while pregnant, were eligible and received services under DHCP throughout the duration of the pregnancy (including any period of retroactive eligibility) and the 12-month postpartum period. Coverage begins on the day the pregnancy ends and continues through the last day of the month in which the 12-months ends.

For individuals first enrolled at the end of their pregnancy, the regularly-scheduled renewal date may coincide with the end of the extended 12-month postpartum period. For most, however, the 12-month postpartum period will end after their regularly-scheduled renewal date. Therefore, the renewal must be conducted at the end of the individual's extended 12-month postpartum period and not at the regularly-scheduled renewal date.

A child may not be terminated during a period of 12-month postpartum continuous eligibility, regardless of change in circumstances, unless:

- The child or child's representative requests a voluntary termination of eligibility;
- The child ceases to be a resident of the State;
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- The child dies.

Unlike continuous eligibility for children, 12-month postpartum continuous eligibility may not be terminated due to:

- Non-payment of premiums,
- A child turning 19 years old, or
- A child becoming eligible for Medicaid.

***Please Note: Due to formatting of certain amendments to the regulation, they are not being published here.**

Copies of the documents are available at:

http://regulations.delaware.gov/register/august2022/proposed/CHIP CS27 Continuous Eligibility.pdf
http://regulations.delaware.gov/register/august2022/proposed/CHIP CS27 Continuous Eligibility Strikthrough.pdf
http://regulations.delaware.gov/register/august2022/proposed/MA 19a1.pdf

13 DE Reg. 1540 (06/01/10)
14 DE Reg. 1361 (06/01/11)
17 DE Reg. 503 (11/01/13)
26 DE Reg. 92 (08/01/22) (Prop.)